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I

110TH CONGRESS
1ST SESSION

H. R. 4232

To improve mental and substance use health care.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 15, 2007

Mr. KENNEDY (for himself and Mr. RAMSTAD) introduced the following bill;
which was referred to the Committee on Energy and Commerce

A BILL

To improve mental and substance use health care.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS; FINDINGS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Improving the Quality of Mental and Substance Use
6 Health Care Act of 2007”.

7 (b) **TABLE OF CONTENTS.**—The table of contents of
8 this Act is as follows:

Sec. 1. Short title; table of contents; findings.

Sec. 2. Evidence-based mental and substance use health care.

Sec. 3. Improved coordination of care.

Sec. 4. Information technology for mental health and substance use health care
providers.

Sec. 5. Council on the Mental Health and Substance Use Health Care Work-
force.

Sec. 6. Funding of research through national centers of excellence.

Sec. 7. Patient-centered care.

Sec. 8. Uniform methodologies for reimbursing behavioral health claims.

Sec. 9. Study on use of public mental health and addiction services by individuals with private health coverage.

Sec. 10. High-quality mental health and substance use health care Medicaid demonstration project.

Sec. 11. Medicaid requirement for State repeal of laws denying health benefits coverage based on intoxication.

1 (c) FINDINGS.—The Congress finds the following:

2 (1) In its study, “Improving the Quality of
3 Health Care for Mental and Substance-Use Condi-
4 tions”, the Institute of Medicine found that each
5 year, more than 33,000,000 Americans use health
6 care services for their mental problems and illnesses,
7 and for conditions resulting from their use of alco-
8 hol, inappropriate use of prescription medications,
9 or, less often, illegal drugs. In the United States,
10 mental and substance use illnesses (which often
11 occur together) are the leading cause of death and
12 disability for women, the highest for men ages 15 to
13 44, and the second highest for all men.

14 (2) Effective treatments for these medical ill-
15 nesses exist, but multiple barriers prevent many
16 from receiving them. The consequences of these bar-
17 riers are serious for these individuals and their fami-
18 lies, for their employers and the workforce, for the
19 Nation’s economy, and for the Nation’s education,
20 welfare, and justice systems. The Institute of Medi-
21 cine further found that a comprehensive approach is

1 needed to remedy this issue that addresses the dis-
2 tinguishing characteristics of mental and substance
3 use health care in the United States.

4 (3) The Institute of Medicine recommended a
5 multifaceted and comprehensive strategy to improve
6 the quality of mental and substance use health care
7 in the United States and thereby ensure that—

8 (A) individual patient preferences, needs,
9 and values prevail in the face of residual stig-
10 ma, discrimination, and coercion into treatment;

11 (B) the necessary infrastructure exists to
12 produce scientific evidence more quickly and
13 promote its application in patient care;

14 (C) multiple providers' care of the same
15 patient is coordinated;

16 (D) emerging information technology re-
17 lated to health care benefits people with mental
18 or substance use problems and illnesses;

19 (E) the health care workforce has the edu-
20 cation, training, and capacity to deliver high-
21 quality care for mental and substance use con-
22 ditions; and

23 (F) government programs, employers, and
24 other group purchasers of health care for men-
25 tal and substance use conditions use their dol-

1 lars in ways that support the delivery of high-
2 quality care.

3 (4) To implement this strategy, the Institute of
4 Medicine noted that action is needed from many
5 health care leaders, including the Congress.

6 **SEC. 2. EVIDENCE-BASED MENTAL AND SUBSTANCE USE**
7 **HEALTH CARE.**

8 (a) COMMISSION FOR EVIDENCE-BASED MENTAL
9 AND SUBSTANCE USE HEALTH CARE.—

10 (1) ESTABLISHMENT.—The Secretary of Health
11 and Human Services (in this Act referred to as the
12 “Secretary”) shall establish a Commission for Evi-
13 dence-Based Mental and Substance Use Health Care
14 (in this section referred to as the “Commission”) to
15 strengthen, coordinate, and consolidate the synthesis
16 and dissemination of evidence on effective mental
17 and substance use treatments and services.

18 (2) DUTIES.—For the purposes described in
19 paragraph (1), the Commission shall, on an ongoing
20 basis—

21 (A) identify, describe, and categorize the
22 available evidence-based preventive, diagnostic,
23 and therapeutic interventions (including screen-
24 ing, diagnostic, and symptom-monitoring tools),

1 including interventions for various age and eth-
2 nic groups;

3 (B) recommend procedure and payment
4 codes and definitions for such evidence-based
5 interventions and tools for their use in adminis-
6 trative datasets under part C of title XI of the
7 Social Security Act and recommend standards
8 for health data collection relating to such inter-
9 ventions;

10 (C) identify on an annual basis priority
11 areas for research on—

12 (i) the development of new evidence-
13 based preventive, diagnostic, and thera-
14 peutic interventions;

15 (ii) comparative effectiveness and cost
16 effectiveness of existing interventions and
17 new evidence-based interventions; and

18 (iii) how best to translate new evi-
19 dence-based findings into practice in com-
20 munity-based clinical settings.

21 (D) recommend to the Director of the Na-
22 tional Institute of Mental Health, the Director
23 of the National Institute on Drug Abuse, the
24 Director of the National Institute on Alcohol
25 Abuse and Alcoholism, and other Federal offi-

1 cials methods to coordinate the conduct or sup-
2 port of research described in subparagraph (C);

3 (E) collect, synthesize, and disseminate in-
4 formation on research concerning evidence-
5 based strategies for promoting the use of evi-
6 dence-based preventive, diagnostic, and thera-
7 peutic interventions;

8 (F) provide guidance on effective mental
9 and substance use interventions to Federal
10 agencies that provide or support such interven-
11 tions, including the Centers for Medicare &
12 Medicaid Services, the Substance Abuse and
13 Mental Health Services Administration, the
14 Agency for Healthcare Research and Quality,
15 the Centers for Disease Control and Prevention,
16 the Health Resources and Services Administra-
17 tion, the Department of Defense, the Depart-
18 ment of Veterans Affairs, the Indian Health
19 Service, and the Bureau of Prisons; and

20 (G) periodically assess the progress of
21 agencies described in subparagraph (F) in im-
22 plementing such interventions.

23 (3) CONSULTATION.—In carrying out this sec-
24 tion, the Commission shall—

(A) seek consultation from leading public and private State and national authorities, and consolidate evidence, opinions, and findings of these authorities as they see fit; and

(B) ensure that interested parties have opportunities to provide input before the Commission makes recommendations or decisions.

(4) MEMBERSHIP.—The Commission shall be composed of not fewer than 15 and not more than 20 members, who shall be appointed by the President from among experts in evidence-based mental and substance use health care. Such members shall include—

(A) researchers;

(B) practitioners from various specialties, professions, and practice settings;

(C) mental health and substance abuse health care consumers; and

(D) health care payers.

(5) TERMS.—

(A) IN GENERAL.—Each member of the Commission shall be appointed for a term of 4 years, except as provided in subparagraphs (B) and (C).

1 (B) TERMS OF INITIAL APPOINTEES.—As
2 designated by the President at the time of ap-
3 pointment, of the members of the Commission
4 first appointed, $\frac{1}{4}$ shall each be appointed for
5 terms of 1, 2, and 3 years and the remainder
6 shall be appointed for a term of 4 years.

7 (C) VACANCIES.—Any member appointed
8 to fill a vacancy occurring before the expiration
9 of the term for which the member's predecessor
10 was appointed shall be appointed only for the
11 remainder of that term. A member may serve
12 after the expiration of that member's term until
13 a successor has taken office.

14 (b) CMS ANNUAL REPORT.—The Administrator of
15 the Centers for Medicare & Medicaid Services shall report
16 annually to the Congress on the extent to which the Med-
17 icaid program under title XIX of the Social Security Act
18 provides coverage of evidence-based interventions identi-
19 fied by the Commission, including—

20 (1) a list of those interventions not so covered
21 and the reasons why they are not covered;

22 (2) a justification for each evidence-based inter-
23 vention that is not so covered; and

24 (3) a list of evidence-based interventions that
25 can be covered only with statutory change.

1 (c) CONSTRUCTION REGARDING APPLICATION.—

2 Nothing in this section shall be construed as requiring,
3 as a condition of payment under the Medicaid program
4 under title XIX of the Social Security Act, that an inter-
5 vention must be an evidence-based practice.

6 (d) PROMPT DEVELOPMENT AND IMPLEMENTATION
7 OF CLAIMS PROCESSING AND DATA CODES.—The Sec-
8 retary, acting through the Administrator of the Centers
9 for Medicare & Medicaid Services, shall establish, or enter
10 into an agreement with, one or more entities for the pur-
11 pose of developing, as soon as practicable after the date
12 of the enactment of this Act, codes that should be applied
13 to claims processing and health data collection activities
14 as recommended by the Commission pursuant to sub-
15 section (a)(2)(B).

16 (e) DEFINITION.—In this section, the term “interven-
17 tion” means a preventive, diagnostic, or therapeutic action
18 with respect to a mental health or substance use disease
19 process.

20 **SEC. 3. IMPROVED COORDINATION OF CARE.**

21 (a) INTERAGENCY COLLABORATIVE GROUP.—

22 (1) ESTABLISHMENT.—The Secretary shall con-
23 vene an interagency collaborative group (in this sec-
24 tion referred to as the “interagency collaborative
25 group”) to provide for the coordination at the clin-

1 ical and programmatic level of mental health and
2 substance use services and primary care services,
3 funded in whole or in part through the Department
4 of Health and Human Services, the Department of
5 Justice, the Department of Veterans Affairs, the De-
6 partment of Defense, and the Department of Edu-
7 cation, using one or more evidence-based coordina-
8 tion models, such as the following:

9 (A) Formal agreements between mental
10 health, substance use, and primary care pro-
11 viders.

12 (B) Case management of mental health,
13 substance use, and primary care.

14 (C) Co-location of mental health, substance
15 use, and primary care providers.

16 (D) Delivery of mental health, substance
17 use, and primary care in integrated practices.

18 (2) DUTIES.—The interagency collaborative
19 group shall—

20 (A) develop a plan for government agencies
21 to implement the recommendations made by the
22 Commission for Evidence-Based Mental and
23 Substance Use Health Care;

1 (B) coordinate with States and appropriate
2 public stakeholders to foster interagency col-
3 laboration at the State and local level;

4 (C) make recommendations to the Presi-
5 dent and the Congress to break down barriers
6 to coordination of existing Federal programs
7 funding mental health and substance use serv-
8 ices and to allow for more effective integration
9 of such programs across agencies and pro-
10 grams;

11 (D) assess progress toward such coordina-
12 tion through development and monitoring of
13 performance measures of coordination; and

14 (E) report to the Congress biannually on
15 the status of such coordination.

16 (3) COMPOSITION.—The interagency collabo-
17 rative group shall include the following members:

18 (A) The Secretary of Health and Human
19 Services (or the Secretary's designee).

20 (B) The Attorney General (or the Attorney
21 General's designee).

22 (C) The Secretary of Veterans Affairs (or
23 such Secretary's designee).

24 (D) The Secretary of Defense (or such
25 Secretary's designee).

1 (E) The Secretary of Education (or such
2 Secretary's designee).

3 (4) MEETINGS.—The interagency collaborative
4 group shall meet not less than quarterly.

5 (5) STAFF AND SUPPORT.—The Secretary shall
6 provide, without the requirement for reimbursement,
7 staff and other administrative support necessary for
8 the operation of the interagency collaborative group.

9 (b) COORDINATED DELIVERY OF CARE.—The Fed-
10 eral agencies participating in the interagency collaborative
11 group shall modify internal policies and practices, to the
12 extent practicable and consistent with legal authority, in
13 order to implement one or more of the evidence-based co-
14 ordination models referred to in subsection (a)(1).

15 (c) NO EFFECT ON HIPAA PRIVACY RULES.—Noth-
16 ing in this section shall be construed to alter the applica-
17 tion of rules promulgated under section 264(c) of the
18 Health Insurance Portability and Accountability Act of
19 1996.

20 (d) GAO REPORT.—Not later than 2 years after the
21 date of the enactment of this Act, the Comptroller General
22 of the United States shall conduct a study and submit a
23 report to the Congress on the implementation of this sec-
24 tion.

1 (e) CLARIFICATION OF MEDICAID REIMBURSEMENT
2 OPTIONS.—The Secretary shall provide, by regulation, for
3 a change in the rules under title XIX of the Social Secu-
4 rity Act relating to reimbursement for primary care serv-
5 ices and mental health and substance use services to the
6 same patient on the same day so as to permit payment
7 for the legitimate provisions of both types of services on
8 the same day to a patient.

9 **SEC. 4. INFORMATION TECHNOLOGY FOR MENTAL HEALTH**
10 **AND SUBSTANCE USE HEALTH CARE PRO-**
11 **VIDERS.**

12 (a) DEVELOPMENT AND IMPLEMENTATION OF
13 PLAN.—The Secretary, acting through the National Coor-
14 dinator for Health Information Technology and the Ad-
15 ministrator of the Substance Abuse and Mental Health
16 Services Administration, shall develop and implement a
17 plan for ensuring that activities of the Department of
18 Health and Human Services to promote the use of infor-
19 mation technology by health care providers include pro-
20 motion of information technology that is accessible and
21 pertinent to mental health and substance use health care
22 providers and consumers.

23 (b) CONTENTS OF PLAN.—The plan developed under
24 subsection (a) shall address—

1 (1) how the development of an electronic health
2 information infrastructure, including the awarding
3 of grants and contracts to promote the use of elec-
4 tronic health records (EHRs), personal health
5 records (PHRs), regional health information organi-
6 zations (RHIOs), and other forms of health informa-
7 tion technology, and the establishment of data
8 standards, will ensure that the needs of mental and
9 substance use health care providers and consumers
10 are met with particular emphasis on the privacy con-
11 cerns of consumers;

12 (2) how financial incentives that are generally
13 made available for the development of such infra-
14 structure for health care providers can be provided
15 to individual mental health and substance use clini-
16 cians and organizations (and particularly publicly-
17 funded providers) for investments in information
18 technology to enable them to participate on a full
19 and equal basis in the emerging electronic health in-
20 frastructure;

21 (3) how any continuing technical assistance and
22 training for developing virtual networks may be
23 made available to give individual and small group
24 providers of mental health and substance use serv-
25 ices standard access to software, clinical and popu-

1 lation data and health records, and billing and clin-
2 ical decision-support systems; and

3 (4) how to create and support a continuing
4 mechanism to engage mental health and substance
5 use stakeholders in the public and private sectors in
6 developing consensus-based recommendations for
7 data elements, standards, and processes needed to
8 address unique aspects of information management
9 related to mental and substance use healthcare.

10 (c) CONSIDERATION.—In awarding any grant or con-
11 tract for the development or implementation of any com-
12 ponent of a national electronic health infrastructure, the
13 Secretary shall consider the application of such component
14 to mental health and substance use health care and pro-
15 viders of such care.

16 (d) CONTINUED PRIVACY PROTECTIONS.—In devel-
17 oping or promoting the national electronic health infra-
18 structure, the Secretary shall ensure that privacy and con-
19 fidentiality requirements traditionally applicable to mental
20 health and substance use health care continue to be ap-
21 plied.

22 (e) INCLUSION OF INFORMATION IN REPORTS.—In
23 preparing any report to the Congress relating to the devel-
24 opment or implementation of a national electronic health
25 infrastructure or the promotion of the use of health infor-

1 mation technology, the Secretary shall include information
2 on such development, implementation, or promotion in the
3 field of mental health and substance use treatment.

4 **SEC. 5. COUNCIL ON THE MENTAL HEALTH AND SUB-**
5 **STANCE USE HEALTH CARE WORKFORCE.**

6 (a) **ESTABLISHMENT.**—The Secretary shall establish
7 a public-private advisory group called the Council on the
8 Mental Health and Substance Use Health Care Workforce
9 (in this section referred to as the “Council”).

10 (b) **DUTIES.**—

11 (1) **DEVELOPMENT OF COMPREHENSIVE**
12 **PLAN.**—The Council shall develop and publish a
13 comprehensive plan for purpose of strengthening the
14 capacity of the workforce to deliver high-quality
15 mental health and substance use health care.

16 (2) **PLAN CONTENTS.**—The plan developed
17 under this subsection shall—

18 (A) identify the specific clinical com-
19 petencies that all mental health and substance
20 use professionals should possess to be certified
21 or licensed and the competencies, including a
22 component of patient centered care, that should
23 be maintained over time;

24 (B) propose national standards for the
25 credentialing and licensure of mental health and

1 substance use health care providers based on
2 core competencies that should be included in
3 curricula and education programs across all the
4 mental health and substance use disciplines and
5 make recommendations regarding accreditation
6 standards for mental health and substance use
7 health care programs;

8 (C) propose programs for funding from
9 Federal, State, and local governments and the
10 private sector to address and resolve long-
11 standing workforce issues such as diversity, cul-
12 tural relevance, faculty development, training
13 effectiveness, continuing shortages of well-
14 trained clinicians needed to work with children
15 and the elderly and in high-need areas, and pro-
16 grams for training competent clinical super-
17 visors and administrators; and

18 (D) provide for continuing assessment of
19 mental health and substance use workforce
20 trends, issues, and financing policies.

21 (3) EVALUATION; REPORTING.—On a biannual
22 basis, the Council shall—

23 (A) conduct an evaluation of the extent to
24 which the purpose specified in paragraph (1)
25 has been met; and

1 (B) submit a report to the Congress on the
2 results of such evaluation, including a descrip-
3 tion of the status of the mental health and sub-
4 stance use health care workforce.

5 (4) ASSISTANCE.—The Council shall collaborate
6 with private sector coalitions to facilitate and imple-
7 ment its recommendations.

8 (c) MEMBERSHIP.—

9 (1) NUMBER; APPOINTMENT; CHAIR.—The
10 Council shall be composed of not less than 21 and
11 not more than 25 individuals appointed by the Sec-
12 retary. The Council shall elect a chair from among
13 its members.

14 (2) PUBLIC SECTOR MEMBERS.—The Council
15 shall include the following officials (or their des-
16 ignees):

17 (A) The Assistant Secretary for Health in
18 the Department of Health and Human Services.

19 (B) The Administrator of the Centers for
20 Medicare & Medicaid Services.

21 (C) The Administrator of the Substance
22 Abuse and Mental Health Services Administra-
23 tion.

24 (D) The Secretary of Veterans Affairs.

1 (3) PRIVATE SECTOR MEMBERS.—The Council
2 shall include representatives from the substance use
3 and mental health services and consumer commu-
4 nities who are not employees of the Federal Govern-
5 ment. Such representatives shall be appointed by the
6 Secretary without regard to the Federal civil service
7 laws and shall include the following:

8 (A) One individual selected from full-time
9 students enrolled in mental health training pro-
10 grams.

11 (B) One individual selected from full-time
12 students enrolled in substance use health care
13 training programs.

14 (C) One individual selected from mental
15 health consumers.

16 (D) One individual selected from substance
17 use health care consumers.

18 (E) One individual selected from faculty
19 members at mental health training facilities.

20 (F) One individual selected from faculty
21 members at substance use health care training
22 facilities.

23 (G) Five individuals selected from among
24 leading professional associations in the various
25 fields charged with carrying out mental health

1 and substance use services, including psychi-
2 atry, addiction medicine, psychology, social
3 work, psychiatric nursing, counseling, marriage
4 and family therapy, pastoral counseling, psycho-
5 social rehabilitation, and substance use treat-
6 ment counselors.

7 (H) Five individuals selected from among
8 leading professional licensing and credentialing
9 entities in the various fields charged with car-
10 rying out mental health and substance use serv-
11 ices including psychiatry, addiction medicine,
12 psychology, social work, psychiatric nursing,
13 counseling, marriage and family therapy, pas-
14 toral counseling, psychosocial rehabilitation,
15 and substance use treatment counseling.

16 (4) SELECTION.—In selecting the members of
17 the Council under paragraph (3), the Secretary shall
18 ensure—

19 (A) the inclusion of both urban and rural
20 members;

21 (B) a range of members from a variety of
22 practice settings and including expertise in pre-
23 vention and treatment across the lifespan;

1 (C) adequate representation of racial, eth-
2 nic, religious, and economic diversity in its
3 membership; and

4 (D) the members appointed under sub-
5 paragraphs (G) and (H) of paragraph (3) are
6 equitably distributed between those specializing
7 in mental health services and those specializing
8 in substance use services.

9 (5) TERMS.—

10 (A) IN GENERAL.—Each member of the
11 Council under paragraph (3) shall be appointed
12 for a term of 4 years, except that except as pro-
13 vided in subparagraphs (B) and (C).

14 (B) TERMS OF INITIAL APPOINTEES.—As
15 designated by the Secretary at the time of ap-
16 pointment, of the members of the Council first
17 appointed under paragraph (3), $\frac{1}{4}$ shall each
18 be appointed for terms of 1, 2, and 3 years and
19 the remainder shall be appointed for a term of
20 4 years.

21 (C) VACANCIES.—Any member appointed
22 under paragraph (3) to fill a vacancy occurring
23 before the expiration of the term for which the
24 member's predecessor was appointed shall be
25 appointed only for the remainder of that term.

1 A member may serve after the expiration of
2 that member's term until a successor has taken
3 office.

4 (d) MEETINGS.—The Council shall conduct at least
5 3 meetings each year.

6 (e) STAFF AND SUPPORT.—The Secretary shall pro-
7 vide, without the requirement for reimbursement, staff
8 and other administrative support necessary for the oper-
9 ation of the Council.

10 **SEC. 6. FUNDING OF RESEARCH THROUGH NATIONAL CEN-**
11 **TERS OF EXCELLENCE.**

12 (a) GRANTS.—The Director of the National Insti-
13 tutes of Health (in this section referred to as the “Direc-
14 tor of NIH”), acting through the Directors of the National
15 Institute of Mental Health, the National Institute of Drug
16 Abuse, and the National Institute on Alcohol Abuse and
17 Alcoholism, and in consultation with the Administrator of
18 the Substance Abuse and Mental Health Services Admin-
19 istration, shall make grants to entities to fund a network
20 of national centers of excellence in mental health and sub-
21 stance use health care.

22 (b) USE OF FUNDS.—As a condition on receipt of
23 a grant under this section, an entity shall agree to use
24 the grant to establish or support one or more centers of

1 excellence in mental health and substance use health care.

2 Each such center shall—

3 (1) integrate basic, clinical, or health services
4 research with interventions in a range of usual set-
5 tings of care delivery and involve a broad cross-sec-
6 tion of mental health and substance use health care
7 stakeholders; and

8 (2) develop innovative approaches to tie to-
9 gether research and practice in order to develop a
10 research agenda relevant to providers of mental
11 health and substance use health care services in a
12 range of usual settings of care.

13 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
14 out this section, there are authorized to be appropriated
15 \$10,000,000 for fiscal year 2008, \$15,000,000 for fiscal
16 year 2009, \$20,000,000 for fiscal year 2010, \$25,000,000
17 for fiscal year 2011, and such sums as may be necessary
18 for each subsequent fiscal year.

19 **SEC. 7. PATIENT-CENTERED CARE.**

20 (a) PROMOTION IN FEDERAL PROGRAMS.—With re-
21 spect to any program that provides for the Department
22 of Health and Human Services, the Department of Jus-
23 tice, the Department of Veterans Affairs, Department of
24 Defense, or the Department of Education to pay for or

1 provide mental health and substance use care, each such
2 Department shall provide for the following:

3 (1) Within the authority of the Department
4 with respect to such program—

5 (A) include payment for, or provision of,
6 peer support and illness self-management pro-
7 grams that meet evidence-based standards for
8 individuals with chronic mental illnesses or sub-
9 stance use dependence; and

10 (B) provide for appropriate payment and
11 coverage reforms, such as the application of co-
12 payments; service exclusions, and benefit limits,
13 so as to eliminate barriers to the effective, ap-
14 propriate, and evidence-based provision of such
15 care.

16 (2) Endeavor to make reliable comparative in-
17 formation on the quality of such care provided by
18 practitioners and organizations available to con-
19 sumers and to encourage consumers to use this in-
20 formation when making decisions about from whom
21 to receive such care.

22 (3) Insofar as the Department does not have
23 authority described in paragraph (1), make rec-
24 ommendations to the Congress regarding changes in
25 law to provide for such authority.

1 (b) SENSE OF CONGRESS FOR ALL PROGRAMS.—It
2 is the sense of the Congress that clinicians and organiza-
3 tions providing mental health and substance use treatment
4 services should—

5 (1) incorporate, consistent with applicable State
6 laws, informed, patient-centered decision-making and
7 (for children) informed family decision-making
8 throughout their practices, including active patient
9 participation in the design and revision of the pa-
10 tient treatment and recovery plans, psychiatric ad-
11 vance directives, and provision of information on the
12 availability and effectiveness of mental health and
13 substance use treatment options;

14 (2) adopt recovery-oriented and illness self-
15 management practices that support patient pref-
16 erence for treatment (including medications), peer
17 support, and other elements of the wellness recovery
18 plan; and

19 (3) maintain effective, formal linkages with
20 community resources to support patient illness self-
21 management and recovery.

22 **SEC. 8. UNIFORM METHODOLOGIES FOR REIMBURSING BE-**
23 **HAVIORAL HEALTH CLAIMS.**

24 (a) IN GENERAL.—The Secretary, through the work-
25 ing group convened under subsection (b), shall develop

1 uniform methodologies across geographic areas and types
2 of payers for the following with respect to medical assist-
3 ance, related services, and administrative costs furnished
4 to individuals with mental illnesses and substance use dis-
5 orders in both community-based and residential settings:

6 (1) Qualifications for eligibility for payment.

7 (2) Financial auditing.

8 (3) Claims payment (including billing codes).

9 (b) CONVENING OF WORKING GROUP.—The Sec-
10 retary shall carry out subsection (a) by convening a work-
11 ing group is composed of the Directors and Administrators
12 of all relevant agencies, including the Centers for Medicare
13 & Medicaid Services, the Office of Management and Budg-
14 et, the Health Resources and Services Administration, the
15 Substance Abuse and Mental Health Services Administra-
16 tion, the office of the Inspector General of the Department
17 of Health and Human Services, acting jointly with State
18 Medicaid directors and other State, local, and private
19 healthcare payers.

20 (c) REQUIREMENTS.—The methodology developed
21 under subsection (a)—

22 (1) shall not result in new medical necessity cri-
23 teria, and shall not prohibit or restrict payment for
24 medical assistance, related services, and administra-
25 tive activities under title XIX of the Social Security

1 Act that are provided or conducted in accordance
2 with options under such title regarding targeted case
3 management, rehabilitative services, or clinical serv-
4 ices; and

5 (2) with respect to administrative costs, shall be
6 based on—

7 (A) standards related to time studies and
8 populations estimates; and

9 (B) a national standard for determining
10 payment of such costs.

11 (d) RULE OF CONSTRUCTION.—Nothing in this sec-
12 tion shall be construed as requiring, as a condition of pay-
13 ment under the Medicaid program under title XIX of the
14 Social Security Act, that an intervention must be an evi-
15 dence-based practice.

16 **SEC. 9. STUDY ON USE OF PUBLIC MENTAL HEALTH AND**
17 **ADDICTION SERVICES BY INDIVIDUALS WITH**
18 **PRIVATE HEALTH COVERAGE.**

19 (a) IN GENERAL.—The Comptroller General of the
20 United States shall conduct a study on the use of publicly
21 supported mental health and addiction services by individ-
22 uals who have any level of private health insurance cov-
23 erage.

1 (b) REPORT.—The Comptroller General shall submit
2 to the Congress a report on the study under subsection
3 (a). The report shall include a description of—

4 (1) the number of individuals described in sub-
5 section (a);

6 (2) the types of private health insurance cov-
7 erage involved; and

8 (3) the public programs providing the mental
9 health and addiction services involved and the cost
10 of such services provided.

11 **SEC. 10. HIGH-QUALITY MENTAL HEALTH AND SUBSTANCE**
12 **USE HEALTH CARE MEDICAID DEMONSTRA-**
13 **TION PROJECT.**

14 (a) IN GENERAL.—The Secretary shall establish a 5-
15 year demonstration project (in this section referred to as
16 the “project”) designed to demonstrate the impact of cre-
17 ating delivery and financing structures that deliver high-
18 quality, integrated mental health and substance use health
19 care. Such project shall be based upon the report of the
20 Institute of Medicine (of November 2005) relating to Im-
21 proving the Quality of Health Care for Mental and Sub-
22 stance-Use Conditions: Quality Chasm Series, and shall
23 include demonstrating at least the following:

1 (1) Coordinated delivery of mental health, sub-
2 stance use, and primary health care, utilizing a co-
3 location or integrated delivery model.

4 (2) Use of evidence-based practices, to as great
5 an extent as possible.

6 (3) Provision of patient-centered care that em-
7 phasizes recovery-oriented practices and informed
8 patients and, where appropriate, family decision-
9 making.

10 (4) A commitment to utilizing health informa-
11 tion technology to improve the quality and efficiency
12 of care.

13 (b) REQUIRED REPORTING ON QUALITY.—The Sec-
14 retary shall provide that each health care provider partici-
15 pating in the project shall submit data on quality meas-
16 ures determined by the Secretary.

17 (c) WAIVER OF REQUIREMENTS.—

18 (1) IN GENERAL.—Subject to paragraph (2),
19 the Secretary is authorized to waive such require-
20 ments of title XIX of the Social Security Act, such
21 as statewideness, a limitation on the scope of serv-
22 ices included in medical assistance, and the coverage
23 of additional administrative expenses, as may be
24 necessary for the implementation of the project.

1 (2) LIMITATION ON FUNDING.—The Secretary
2 shall design the project in such a manner so that the
3 net additional Federal expenditures under title XIX
4 of the Social Security Act resulting from the project
5 does not exceed \$50,000,000.

6 (d) INDEPENDENT EVALUATION.—The Secretary
7 shall provide for an independent evaluation of activities
8 provided under the project, in comparison with a control
9 group. Such evaluation shall include an assessment of
10 health and social outcomes for beneficiary participants,
11 such as employment status, receipt of welfare benefits,
12 criminal justice contacts, and homelessness, as well as the
13 resource utilization for medical services, mental and sub-
14 stance use health care, and social services. Such evaluation
15 shall also include an assessment of the impact of activities
16 provided under the project on workforce recruitment and
17 retention.

18 (e) REPORTS TO CONGRESS.—

19 (1) INTERIM REPORT.—Not later than two
20 years after the initiation of the project, the Sec-
21 retary shall submit to the Congress an interim re-
22 port on the project. Such report shall include such
23 recommendations as the Secretary determines appro-
24 priate.

(2) FINAL REPORT.—Not later than one year after the completion of the project, the Secretary shall submit to the Congress a final report on the project. The report shall include the results of the independent evaluation provided under subsection (d) as well as recommendations regarding redesign of the mental health and substance use benefit under the Medicaid program to maximize the quality and efficiency of such benefits.

**SEC. 11. MEDICAID REQUIREMENT FOR STATE REPEAL OF
LAWS DENYING HEALTH BENEFITS COV-
ERAGE BASED ON INTOXICATION.**

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (69);

(B) by striking the period at the end of paragraph (70) and inserting “; and”; and

(C) by inserting after paragraph (70) the following new paragraph:

“(71) provide that the State has in effect a law that requires any insurance contract covering medical care losses in the group and individual market

1 that is to be offered in the State to meet the re-
2 quirements of subsection (dd)(1).”; and

3 (2) by adding at the end the following new sub-
4 section:

5 “(dd) REQUIREMENTS FOR INSURANCE COVERING
6 MEDICAL LOSSES IN THE GROUP AND INDIVIDUAL MAR-
7 KET.—

8 “(1) RESTRICTIONS ON EXCLUSIONS AND LIMI-
9 TATIONS RELATING TO INTOXICATION.—The re-
10 quirements of this paragraph with respect to insur-
11 ance contracts covering medical care losses in the
12 group and individual market are as follows:

13 “(A) A prohibition against the exclusion or
14 denial of covered services and benefits, in con-
15 nection with the treatment of any patient whose
16 medical condition, illness, or injury, involves
17 confirmed or suspected intoxication as a result
18 of alcohol or other substance.

19 “(B) A prohibition against discrimination
20 against health care providers in the rate or level
21 of payment for covered services in cases in
22 which intoxication is either suspected or con-
23 firmed.

24 “(C) An express obligation to provide and
25 pay for covered services and treatments nec-

1 essary to the treatment of any condition, illness
2 or injury without regard to whether intoxication
3 is either suspected or confirmed.

4 “(D) An express obligation to cooperate
5 with the state agency for medical assistance as
6 provided under section 1902(a)(25).

7 “(2) INCLUSION OF ALL FORMS OF COV-
8 ERAGE.—For purposes of subsection (a)(71) and
9 paragraph (1), the term ‘insurance contract covering
10 medical care losses in the group and individual mar-
11 ket’ includes any class or type of insurance relating
12 to medical care in the group or individual market,
13 including plans covering public employees as well as
14 private employees, regardless of whether coverage
15 under the contract is expressed in terms of defined
16 benefits or defined cash contributions toward the
17 cost of medical losses.”.

18 (b) EFFECTIVE DATE.—

19 (1) Except as provided in paragraph (2), the
20 amendments made by subsection (a) shall apply to
21 calendar quarters beginning on or after January 1,
22 2008, without regard to whether or not final regula-
23 tions to carry out such amendments have been pro-
24 mulgated by such date.

1 (2) In the case of a State plan for medical as-
2 sistance under title XIX of the Social Security Act
3 which the Secretary determines requires State legis-
4 lation (other than legislation appropriating funds) in
5 order for the plan to meet the additional require-
6 ments imposed by the amendments made by sub-
7 section (a), the State plan shall not be regarded as
8 failing to comply with the requirements of such title
9 solely on the basis of its failure to meet these addi-
10 tional requirements before the first day of the first
11 calendar quarter beginning after the close of the
12 first regular session of the State legislature that be-
13 gins after the date of the enactment of this Act. For
14 purposes of the previous sentence, in the case of a
15 State that has a 2-year legislative session, each year
16 of such session shall be deemed to be a separate reg-
17 ular session of the State legislature.

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